This case history of a community mental health center in the South Bronx in New York City illustrates the difficulty encountered by such a facility in fulfilling a public health responsibility. At the same time the author indicates how such a challenge may lead to new approaches and new ways of delivering health services.

A CANDID APPRAISAL OF THE COMMUNITY MENTAL HEALTH CENTER AS A PUBLIC HEALTH AGENCY: A CASE HISTORY

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As director of a comprehensive community mental health center, I am the public health official responsible for supplying mental health services to some 350,000 people inhabiting five square miles of the South Bronx in New York City. The organization I direct, Lincoln Hospital Mental Health Services, was established in November, 1963, under a contract between the City of New York and the Albert Einstein College of Medicine. This contract commits the College of Medicine, of which I am a faculty member, to a number of responsibilities, among them: (1) to render psychiatric services in the clinics and emergency room areas; (2) to give consultative services to inpatients of the hospital; (3) to give consultation and psychiatric services to public agencies and organizations; (4) to set up programs for rendering psychiatric services to the residents of the district served by the hospital; and (5) to give care to patients who are considered by the university staff to suffer from a psychiatric disorder, or whose mental health is endangered or impaired. To understate considerably, this is a broad mandate: to provide this population with the entire spectrum of services supposedly at the fingertips of modern psychiatry.

Both the College of Medicine that signed this contract and its Department of Psychiatry, which agreed to carry it out, enjoy enviable reputations. When I assumed the directorship of the services, I assumed, in effect, a mandate, a title, a skeleton staff, and a major moral responsibility. If, however, I take my responsibilities as this kind of public health official seriously, should I not, in all conscience, resign? For, to use an analogy from the more traditional public health arena, I am in the position of a man who has been assigned the responsibility for controlling diphtheria or smallpox in a community but has been given neither the materials, the authority, nor the personnel to carry out his assignment.

Admittedly, the analogy is not perfect. We know considerably less, for example, about the etiology of schizophrenia than we do about that of diphtheria and smallpox. Nevertheless, we do treat schizophrenia, albeit empirically, and at least we have learned something about how to

avoid exacerbating its symptoms. One of our more important pragmatic discoveries has been that the prolonged and often unnecessary hospitalizations and rehospitalizations imposed on so many schizophrenics from low socioeconomic areas may result in that iatrogenic syndrome referred to as "hospitalism." Thus, in the South Bronx, in the year ending March, 1965, there were 52 per cent more state hospital commitments than there were for the year ending March, 1961. The rate of admissions in 1965, per 1,000 persons, was 33.3 per cent higher than that for the Bronx as a whole, and 30.4 per cent higher than that for New York City. Can we assume, on any basis of probability, that there are more—and more severe—psychotics in the South Bronx than in the city as a whole, or must we face the reality that the South Bronx is a deprived, disadvantaged, urban area, racially ghettoized, and suffering from all the social clinical symptoms we find in this kind of urban syndrome? If healthy young people have difficulty in getting jobs, keeping their families together, finding a decent place to live, what then becomes of the aging schizophrenic who has no family, no home, no suitable housing, no job to return to from a hospital? Obviously, he is likely to remain where he is.

If you view the comprehensive community mental health center as a public health agency in the current conventional sense, you might reasonably insist that problems of bad housing, high rates of unemployment, socioeconomic problems are not in themselves the legitimate concern of such an organization. What then is the appropriate posture of the agency in regard to those issues encountered in the population that cannot be neatly delineated from the socioeconomic conditions under which people live?

For example, brain-damaged premature infants born to frightened fifteen-year-olds, are a legitimate concern for a mental health center. From the point of view of developmental psychology, psychoanalysis, or medicine, there can be little argument that such inauspicious beginnings will not lead almost inevitably to serious difficulties in adaptation. In 1965, 41.4 per cent of the women who gave birth to live babies in the South Bronx had had no prenatal care before the sixth month, or no prenatal care at all. This figure is 73 per cent higher than that for the city as a whole. The association between late prenatal care, prematurity, and brain damage is sufficiently well established so that any mental health center might understandably be concerned about the shortage of funds to provide adequate facilities for perinatal care, decent nutrition, or effective education for these youthful South Bronx mothers.

The mental health field has for some time been aware of the intimate triadic association between juvenile delinquency, truancy, and reading disability. In 1961, juvenile delinquency offenses in the South Bronx numbered 1,492; by 1965 the figure had risen to 1,929, a 29.3 per cent increase. The rate per thousand youths was 92.1, as compared to 52.1 for the city as a whole. Turning to reading disability statistics, I find that in 1965 the Board of Education made available the reading scores of 583 eighth-grade students in a South Bronx junior high school. On analysis, we discovered that 19.7 per cent of the students were four to five years behind grade level, 21.3 per cent three to four years behind, and 18.7 per cent two to three years behind. Only 18.9 per cent of these students read at or above grade level. Although we have no really adequate data as yet on truancy, we do know that the rate of absence from school in the South Bronx is substantially higher than that in the Bronx as a whole.

One of the facets of this triadic association most accessible to relatively effective intervention is the syndrome of

reading disability. We have shown that any one of several relatively simple measures can significantly reduce the incidence of reading disability (Peck, Rabban, 1966). As a matter of fact, some educators have suggested that the mere reduction by half in the size of first and second grade classes would in itself produce a substantial improvement, but the general poverty of resources in the South Bronx precludes even this type of apparently simple intervention. School buildings are, for the most part, jammed to the rafters. Often space is not available for even those services deemed essential by the Board of Education.

If, despite their theoretical preventability, there are some forms of pathology that are not curtailed because of factors seemingly outside the control of a mental health center, should such an organization still be viewed as a public health agency?

Let us continue our exploration by examining the mandate given Lincoln Hospital Mental Health Services by the City of New York. How does it compare to the charge given to a public health organization established for such purposes as sanitation control, regulation of the dairy industry to prevent milk contamination, or inoculation against smallpox. Such measures may be realistically demanded of the public health agency because, for the most part, such agencies have both the resources to deal with these problems and the authority to enforce appropriate action. However, the mandate handed us existed only in fantasy because the city had neither the administrative structure, the funds, the physical plant, nor the other necessary facilities to enable us to carry it out. However, the administration was under mounting pressure from a South Bronx community that was begcoming increasingly sophisticated about how much it was being shortchanged. In a territory that houses enough people to fill a fair-sized city, there were, in 1963, almost literally no formal psychiatric or mental health services. Only the year before, the city's effort to fill this gap by supporting the establishment of an outpatient clinic failed, largely because it could not attract enough personnel to staff even such a modest facility.

Certainly, the College of Medicine and its Department of Psychiatry were hardly in a better position to fulfill *their* part of the contract. None of us claimed that we knew how to mount the comprehensive mental health services for the South Bronx that were called for under the contract but the Department of Psychiatry was under pressures that tended to push it in the direction of accepting the contract. For example, the department's service and training facilities at the Bronx Municipal Hospital Center, some miles to the north of the Lincoln area, were becoming strained—in part because of the absence of services in the South Bronx. Furthermore, some of us in the department's Division of Social and Community Psychiatry had been engaged for years in experimental and pilot studies on the development of community mental health services; we felt that we were beginning to assemble a modest body of knowledge, some conceptual orientation, and a few techniques that might prove useful. Therefore, we were interested in trying to apply our knowledge and skills to the kinds of problems presented in the South Bronx, hoping this might ultimately provide us with a training center for some of the personnel who would be needed in new urban mental health centers.

When the city was informed of our interest in utilizing the Lincoln program as a training facility, it accepted the idea —on condition that we use no municipal funds either for this purpose or for anything resembling research. We pointed out that we were assuming responsibility for designing a mental health program for a sizable portion of the city and that

some systematic appraisal of the community to be served was obviously essential to intelligent intervention. The city relented and agreed that we could use personnel for gathering data that would enable us to do program planning and development. However, we were encouraged to designate the functions of such staff in a manner that would suggest they were engaged in more honest and useful pursuits.

The city would hesitate to raise similar questions about the need for such research personnel if they were assigned to perform comparable functions for a health agency's tuberculosis control program. Similarly, the effective mental health center needs a research team that starts to work with the planning group at the inception of the program (Struening, Peck, 1967). The required functions of such a research team undoubtedly approximate the sort of tasks necessary in a more traditional public health effort. Briefly, we feel that the research should provide:

1. A comprehensive description of the community to be served, organized, and changed.
2. A study of the relationship among the variables. This, a second level of analysis, focuses on relationship issues and asks the question: to what extent do environmental characteristics, derived from census tract information, predict the physical health, mental health, and selected behaviors of the area?
3. Assessment of the current resources and needs of the area as perceived by agency heads, community leaders, and the leaders of informal groups.
4. Determination of the need and problem hierarchy of the area as perceived by the citizens.

Relatively few of the community mental health centers that have been organized in recent years have been equipped to mount many of the elements of such a program. It is possible that the need to assess the community in a systematic fashion is not greatly stressed because too few mental health centers have really grasped the differences in approach between the more traditional psychiatric functions in which they were previously engaged and the requirements of a comprehensive effort to intervene within the community as an entity. Our own transition to this position emerged in the course of our work with families, small groups, and the ward milieu of a psychiatric day-hospital, where we had been impressed by the possibility of substantially altering the adaptation of the individual through intervention directed at one or another of these aspects of the social milieu (Peck, 1963). It was but a short step to the assumption around which much of the Lincoln program was developed: namely, that *there is an intimate relationship between the social organization of the community and the psychological organization of its residents.*

The question is whether any strategy can have significant impact on such a high degree of social psychopathology unless it is oriented toward the broadest kind of social change compatible with the over-all mental health mandate. In our area, the existing public and private agency programs acknowledged their own severe limitations, helplessness, and discouragement in the face of the overwhelming tasks confronting them. As for the citizens of the South Bronx, although there was evidence that some groups and organizations were pressing for improvements in conditions and services, they had made no perceptible inroads on the major problems of the area. At first glance the general population seemed either uninvolved or apathetic. Nevertheless, despite or perhaps because of these obstacles, it was clear that the achievement of any major mental health objectives in the community would require substantial alterations both inside and outside the formal agency and institutional structure. The task of delineating an appropriate role for a public mental health organization within these two spheres of action is complicated, delicate, and difficult. Most programs tend to

formulate their activities from the institution "down" or from the people "up." We wondered if it might be possible to develop a coordinated strategy that would combine an emphasis on institutional consultation and training programs with some way of implementing and facilitating those processes of social change and social action around which the community grows and develops, and from which positive mental health objectives might accrue.

As a matter of fact, this approach conditioned our original negotiations with the city authorities. We assumed that the kinds of goals to which we were becoming committed would require institutional changes at various levels within selected municipal agencies. Thus we viewed the initial contract as a reflection of the current status of our relationship with the city—one that was obviously subject to change. We recognized at the outset that our goals would tend to be substantially influenced by our own interests, competence, biases, and identity. Accordingly, we attempted to organize ourselves into a flexible structure that would enable us to continue to learn and respond to what we hoped would be an ever-growing knowledge of the community and its needs. We tried to make some determination of such needs both from the available demographic data and through exchange of information and the establishment of consultative relationships with the departments of the hospital and the various public and private agencies in the community.

The Hospital and the Community

We saw our initial program effort as combining the elements of a study and consultation program directed toward hospital departments and community agencies, focusing particularly on those small leadership groups to which we had access within these organizations. We did a baseline interview study of the Lincoln Hospital departments and an adaptation of this study was used for the more varied community agencies. Interviews were designed to give: qualitative and quantitative information on each department's or agency's present use of, and attitude toward, mental health services; information on their internal structure; and information about their relationships to the departments in the hospital. Analysis of the interviews provided an estimate of the future demands on the mental health services. Thus, we gained a bird's-eye view of the major dynamic features of the hospital as a total operating unit, and some sense of the over-all agency configuration. This information was not only vital to our planning but also established points of reference around which we could organize observations of change.

It was evident from the outset that the needs for direct service expressed by such departments as Medicine, Pediatrics, or Ob-Gyn, or such agencies as the public schools, could, if acceded to, swamp all of the available mental health staff resources with referred cases. We therefore created a Multipurpose Clinical Facility, initially designed as the primary instrument for relating to the departments of the hospital and the various public and voluntary community agencies. The functions of the facility differ somewhat from those of the usual psychiatric outpatient or mental hygiene clinic. The Multipurpose Clinical Facility provides information, referral, diagnostic, and consultation services. However, treatment contacts are mostly crisis-oriented, and are generally limited to about six individual or family interviews. All such contacts are viewed as opportunities to gain access to any one of a variety of subsystems of which the primary patient is a member and which may be in crisis (Peck and Kaplan, 1966). Thus, wherever feasible, an attempt is made to investigate the individual's association with one or another

aspect of his social milieu which may bear on the difficulty that leads him to seek help. In practice, this approach leads to the involvement of the total family in the evaluation and treatment, with particular attention to the welfare, housing, or other realistic social concerns which almost always accompany the psychological symptoms in the adult population we serve. Whether help to the individual patient requires assistance to a family in crisis or intervention into some critical aspect of the family's relation with a community agency, we try to address our efforts both to the individual in distress and to that aspect of the social system which appears to be associated with the difficulty.

Limitations of the Initial Organizational Structure

This organizational structure was primarily designed to provide crisis-oriented services, collect data, engage in collaborative planning with hospital departments and community agencies, and to provide, expand, modify, and coordinate services through a program of consultation, training, and direct services. However, experience within our own and other cities suggested that services developed along these lines alone would be far from adequate to meet the needs of an impoverished community like the South Bronx.

The public service agencies, fragmented, complex, and bureaucratized, present a frustrating and seemingly insurmountable network of barriers. In the interest of economy, the voluntary family and children's agencies have abolished neighborhood outposts and now have only one office each to serve the entire Bronx. These are often at considerable distance from those who most need the service. The very complexity of the urban structure makes it difficult and frustrating for people (even long-time residents) to know about and make proper use of resources. Unfamiliarity with the city and the intricacies of its various bureaucratic structures contributes to the individual's sense of powerlessness, anomie, and helplessness as he attempts to deal with problems of employment, housing, education, recreation, income, and the like. Low income people are less able than middle class clients to formulate their needs "acceptably," to state their complaints, or to assert their rights, yet they require the concrete services of some of these systems for sheer survival as well as for their social and psychological well-being. This inability to voice their needs effectively can be a major source of frustration, impotence, and can act as reinforcement of self-defeating behavior.

Equally obstacle ridden are the mental health centers' efforts to enlist the agencies' participation in planning more appropriate services. But in spite of the substantial difficulties in motivating the personnel of a school or welfare department to participate with a mental health agency in planning, modifying, and extending services, there are various levels of communication and authority along which information can be exchanged, influence exerted, and some changes introduced.

No such lines extend from a mental health agency like the Lincoln Hospital Mental Health Services to the informal organizational structure of the South Bronx community, yet its functions may have considerable bearing on why the statistics of a deprived area like the South Bronx are not substantially worse than they are. How else do so many of its residents maintain their sanity, self-esteem, or health? Clearly, this "disorganized" community must—and does—have its own unique, informal network which is at least as effective in maintaining, "treating," and rehabilitating its citizens psychologically and socially as is the very limited and deficient formal agency structure. One of

the tasks of the mental health agency is to learn about this informal network in the community, which so often is invisible to the "outsider." It is necessary to bring together "outside" and "inside" data and resources, and find effective ways to coordinate them all in the interests of the community.

The limitations, then, of our original organizational structure, were:

1. It did not make adequate provision for integrating the so-called "mental health approach" with a social action approach. The former, which seems more closely to resemble public health activities, works within the agency structure through training, consultation, and direct services, while the latter tries to bring about major alterations in the operation and utilization of existing institutional services, to develop new ones, and to alter drastically the level of citizen participation and thus reduce the apathy, powerlessness, and generally poor psychosocial climate of the community.

2. Although some programs could be envisioned as integrating certain of the hospital-based clinical services with those of the public and private community agencies, there was no channel for connecting this formal organizational structure to the extensive, informal community structure's great, unutilized mental health potential. Without such connections it seemed unlikely that we would be able to close those gaps in vital services which are often the lethal chasms in which the lives and minds of the residents of a low-income area are lost.

3. Finally it lacked a form that would keep us from falling into the very bureaucratic pitfalls which seemed to account for so many of the deficiencies in existing services.

a. Coordination and integration seem almost inevitably to lead to increasing organizational size and thus contribute further to the development of impersonal dehumanized services.

b. The more complex the organizational structure becomes, the more difficult it is for the people of the community to find points of entry into the system so that they can make their needs known and participate in its planning or operation.

Without such citizen participation, and despite our best intentions, we might end by contributing further to the community's dependency and apathy rather than by fostering the kind of autonomy that would ensure continuity and development of programs which cannot depend for their survival on the professional community alone.

It also seemed probable that without more direct and extensive access to the community, the likelihood of enlisting its participation in any ultimate plan of intervention would be limited and ineffective.

The Neighborhood Service Center Mental Health Aide Program

In February, 1965, we established a single storefront outpost, which we designated a Neighborhood Service Center. This center was to serve as a base for service and community action programs and to help us become acquainted with the relatively alien world of the South Bronx. To staff the center, we recruited residents of the neighborhood, some of whom had already been engaged in trying to help themselves and their neighbors to deal with their problems and others we thought had potential for doing so. In training them, we tried to add some contribution to the competence and skills they already possessed. We also aspired to learn from them something of their knowledge about the community and the skills they had acquired in living and working within it.

This first Neighborhood Service Center was staffed with six nonprofessional mental health aides under the supervision of a mental health professional. We did not detail the center staff's functions or services. The staff, through their interaction with the residents of the neighborhood, was to ex-

plore the needs of the people and to determine the ways in which we could or could not be helpful.

We were not unduly naive. We knew there were many needs we were not prepared to meet. Some services might be extracted—with difficulty—from various public and voluntary agencies. Still others might require considerable creative innovation or even major alterations in the organizational and power structure of the community. Beginning in January, 1965, we began to receive support from the Community Action Program of the Office of Economic Opportunity, which enabled us to open two additional Neighborhood Service Centers and to train over 50 aides—by then called Community Mental Health Workers.

Our three Neighborhood Service Centers have become the setting to which community residents turn in time of crisis. The centers are able to keep abreast of the kinds of psychosocial problems with which the residents have to cope as well as the services needed and the availability of them. Similarly, the gaps, limitations, and deficiencies in the formal service structure, and the informal alternative arrangements currently available, are detected more readily.

Thus, the centers serve as important sources of information about the nature of the social changes needed as well as potential foci from which action to implement the changes can arise. The initiation of programs varies not only according to the nature of the problem encountered but also varies—in terms of differing priority of needs, relationships to the community, and the like—from one center to the next.

The social action activities, although still limited in scope, are beginning to engage the population receiving service at the centers in a graduated series of tasks of increasing complexity. The Neighborhood Service Centers have been involved in campaigning to register voters, in organizing housing committees and tenant councils working on code enforcement and housing legislation, in organizing block clean-up programs, in discussing complaints against Lincoln Hospital with residents, and in organizing residents to protest against the closing of another much-needed local hospital. In addition to protest activity, the Neighborhood Service Centers have been involved in a variety of collaborative activities with local institutions and agencies such as schools, welfare, and housing organizations.

Conceptual Orientation

This recital of the Lincoln Hospital Mental Health Services "case history" takes us to within a year or so of present activities and future plans. For purposes of this presentation it may now be possible to make some judgment as to whether it is either appropriate or useful to view an organization such as the Lincoln Hospital Mental Health Services as a public health agency. One way of pursuing this question further is to examine the relevance of our conceptual orientation to the more general field of public health.

We have assumed that certain forms of community and social action may be directed toward maintaining certain aspects of human adaptation and competence that are attributes of mental health. In a recent report,* we pointed out that a mental health agency providing services in a socioeconomically deprived area must seek out appropriate forms of social action because it is in such areas that the opportunity to engage in "environmental mastery" (Jahoda, 1958) is

* The conceptual orientation as delineated in condensed fashion in this section is drawn from a more extensive presentation of this point of view in a paper by Peck, Roman, Kaplan, 1967, "Community Action Programs and the Comprehensive Mental Health Center." Psychiatric Research Report No. 21. American Psychiatric Association, 1967.

often a necessary condition for the continuing development and consolidation of other aspects of mental health. Man's psychological functioning is influenced by the mode of his existence, and various studies of severe deprivation suggest that if conditions of stress exceed his minimal adaptational requirements, we may expect disturbances in such areas as self-esteem, perception of reality, and autonomy. It is for this reason that Jahoda cautions: "Some situational requirements, if met, can call for behavior that must be deemed unhealthy when viewed in terms of some other criteria. Severe deprivations, a harsh and demanding teacher, a prison, and the like, all may require behavior precluding self-actualization, autonomy, or perception free from need distortion."

It is, of course, precisely such "harsh" conditions and "severe deprivations" that form a great part of the target of social action programs and that are generally associated with those segments of the population which both manifest the highest indices of psychosocial pathology and are believed to be most vulnerable to mental health "hazards." Adaptation in relation to such environmental conditions, according to Jahoda, means ". . . that a workable arrangement between reality and the individual can be achieved by modifications of either or both through individual initiative."

The difficulty, of course, rests in the fact that many of the environmental conditions associated with severe deprivation cannot be modified solely through "individual initiative." Changes in the conduct of a welfare office or school system, or the opening of employment opportunities, generally require the collaboration of others in some organized and concerted form such as a community action program. Thus, it would seem that both the questions of what goals are achieved by social action and of how the resident of a community participates in such activity may bear significantly on both the individual's mental health status and that of the community at large.

One major objective behind the community mental health center movement is to provide "continuity of care." Technical innovations are designed to improve the capacity of the psychiatric or mental health organizaton to respond more responsibly to the needs of individuals and families. However, it is doubtful whether the mental health center alone can become a more effective and responsible public health agency unless it is integrated into an over-all health and human service organization. It is hoped that this may reduce its deficiencies without sacrificing those functions that are its unique attributes and assets.

Where Do We Go From Here?—A Summary

We assume that a public health agency must have the capacity for establishing its own goals in some planful and rational way. For the Lincoln Hospital Mental Health Services, goals are determined—but only in part—by the interest and competence of its staff, and further modified by the limits imposed by the sponsoring and mandating organization. The directions we took were further influenced through collaborative relationships with certain departments of the hospital and various public and voluntary agencies. However, the development of the Neighborhood Service Centers, staffed primarily with people from the South Bronx community, introduced a new and significant force in the determination of agency goals. In essence, we attempted to establish these new units in a manner which would allow the special interests and commitments of the agency to be submitted to the influence and corrective impact of the community at large. Three years of study and experimentation with this approach have impressed us with both

its enormous value to health and mental programs; it has also raised a number of challenging and, as yet, incompletely resolved problems.

We are persuaded that the kind of direct community participation introduced by the development of neighborhood units that use personnel drawn primarily from that community not only contributes to the more rational determination of goals and priorities but also facilitates the growth of a healthier, more competent community through such participation. Such growth is certainly a very desirable objective for a public health program—yet this very movement toward health and competence appears to be closely associated with developments that may be less familiar—and even alien—to the more traditional health agency. The mental health criteria for competence and health, as Jahoda (1958) has pointed out, are intimately linked to such attributes as autonomy and environmental mastery. When these criteria are translated into programs, they may assume such forms as the engagement of the community in carrying out functions and participating in decisions that have generally been considered the province of agencies staffed by professionals and mandated by government. Furthermore, it appears that—at least in the urban ghetto—if the community is to achieve autonomy and mastery over those forces in the environment that thrust it toward pathology, it must develop various forms of community and social action. It is apparent that some forms of action, essentially political in character, will be initiated without reference to any existing public health agency and rest primarily on the shoulders of those residents and organizations in the community that are most pertinently involved and concerned with such matters. The more difficult question is whether there are forms of institutional change in which it is appropriate for a public health agency to engage. We believe that there are, and that our own experience in recruiting mental health workers from the community points the way to one such strategy—which we refer to as a Health Careers Program (Peck et al., 1969).

The Lincoln Hospital-Albert Einstein College of Medicine Health Careers Program is now in its active planning stages.* It will provide opportunities for residents of the community to enter into careers and training that span a variety of health roles and agencies. Over a period of years, the program is designed to move members of the community into positions within such agencies wherein they may appropriately and competently engage in decision- and policy-making roles in matters of vital concern to their own community's health and well-being. These objectives are to be achieved through a system of fully accredited training programs conducted in conjunction with the pertinent educational institutions.

The strategy of the program, which cannot be detailed in this presentation, is aimed at (a) providing the manpower required for meaningful change in the delivery of health services, (b) bringing about institutional change in the health agencies, and (c) training community leaders who are knowledgeable in the field of health and who can help to bring about change within the informal structure of the residential community.

It cannot be assumed that such strategies as Neighborhood Service Centers or a Health Careers program will in themselves transform a socioeconomically disadvantaged area into a healthy and competent community. However, they do point in a direction that appears to promise more than merely trying to fill the bottomless pit of need

*A grant from the Commonwealth Fund supports a three-year Health Careers planning project which began in September, 1963.

with more traditional "services." These new strategies are being joined with parallel approaches that are already being directed at the socioeconomic and political life of the urban ghetto. The lessons to be learned in such experimentation may well be applicable to the more fortunately endowed areas of the city. As this occurs, many of our accustomed ways of administering health services will undoubtedly continue to be challenged. The disadvantaged community may provide us with a laboratory in which the public health agency can try out new approaches, attempt new postures, and possibly make the necessary modifications in its identity to fulfill its contemporary community obligations on which rest the future of the nation's health and well-being.

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